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AUTHOR Rothblum, Esther D.
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ABSTRACT

This paper discusses possible roles of a counselor in affirming a client's lesbianism. In 1983, it was legal to be a lesbian in only 26 states. Of 55 other countries on which statistics were available, lesbianism was legal in 18 countries. The prevailing view on lesbianism by mental health professionals today seems to be one of cautious acceptance. Mental health professionals need to understand the issues which are vital to the lesbian experience. Most lesbians are single; mental health statistics reveal that being single is psychologically "healthier" for women than being married. Research comparing lesbians and heterosexual women has not found consistent differences in mental health, with the exception of higher self-esteem for lesbians. Lesbianism involves a process of "coming out" and most lesbians are in their 20s before they begin having lesbian relationships. Lesbians usually have fewer and more long-term relationships than gay men. For lesbian couples, there is a large emphasis on emotional closeness, love, and security. Compared with heterosexual women, lesbians are less likely to be in sexually monogamous relationships and are more likely to have personal autonomy. Several issues confront lesbian mothers that are not concerns for heterosexual parents. Hopefully, an understanding of these issues will help to decrease homophobic stereotypes about lesbians and will demonstrate how the lesbian experience can serve as an affirmative model of a nontraditional lifestyle. (NRB)

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LESBIANISM: AFFIRMING NON-TRADITIONAL ROLES

Esther D. Rothblum

University of Vermont

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Requests for reprints may be obtained from Esther D. Rothblum, Department of Psychology, John Dewey Hall, University of Vermont, Burlington, VT 05405.

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LESBIANISM: AFFIRMING NONTRADITIONAL ROLES

Although my talk is on affirming lesbianism, I am aware that lesbianism is illegal in the state of Texas. I am also aware that this is the first presentation on lesbianism in the history of AABT (although there was a workshop on lesbianism last year). I will talk about (1) the current legal and mental health status of lesbians; and (2) how we as mental health professionals can affirm, rather than deny, lesbians' non-traditional roles.

As of 1983, it was legal to be a lesbian in only 26 states, although 40 states protect some civil rights of lesbians and gay males (such as public employment, housing, education, and credit; Morgan, 1984). In practice, the federal government and some companies (including IBM and AT&T) have policies forbidding discrimination against homosexuals, but lesbians can be discharged from the FBI, the CIA, and the military.

In other countries there is also great variability in the legal status of lesbianism. The data on this slide were compiled from Robin Morgan's book Sisterhood is Global (1984) and represent the international legal status of lesbianism as of 1982. Lesbianism is legal in 18 countries out of 55 on which statistics are available. In Thailand, for example, same-sex marriages are not uncommon and may have the blessing of a Buddhist monk. In some countries, laws refer specifically to homosexuality as an offense between men and do not mention lesbianism. Other countries consider lesbianism and male homosexuality an offense against public morality. Finally, 15 countries consider lesbianism illegal. Thus, in Iran, the law states: "If two women are sleeping nude together, they will be warned three times; if they continue, they will be executed" (Morgan, 1984, p.327). Interestingly, nations that consider lesbianism legal include both Moslem (e.g. Indonesia) and Catholic (e.g. Austria) nations, socialist (e.g. Poland) and capitalist (e.g. Canada) nations, developed (e.g. Denmark) and developing (e.g. Guatamala) nations, and nations from various continents. Where does the United States stand? In this country, the legality of lesbianism is determined on a state-by-state basis. Obviously, legal status does not always correlate with practice or tolerance. For example, Argentina has laws prohibiting public displays of lesbianism, yet lesbians in Argentina are being tortured and murdered by the government. And, of course, it is illegal for any lesbian from another country to enter the United States, even on a tourist visa.

The majority of Americans consider homsexuality, lesbianism included, obscene, vulgar, and "harmful to American life" (Hyde & Rosenberg, 1980). The stigma of lesbianism runs counter to thirty years of research indicating that lesbians experience positive adjustment and mental health. Did you ever wonder what the first entry on lesbianism in Psychological Abstracts was on? It's an article by Davis in 1927 describing a survey of 1,000 married and 1,000 unmarried women. Homosexual experiences were reported by 18.4% of the married women and 16% of the unmarried women (before their marriage). More recently, ten percent of the women who responded to the Hite Report survey in 1976 were lesbians. In 1971, Thompson, McCandless, and Strickland

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matched male and female heterosexuals and homosexuals on age, gender, and education, and presented them with several personality measures. There were no significant differences between heterosexuals and homosexuals of either gender on personal adjustment, self-confidence, and self-evaluation. In fact, there was a tendency for lesbians to be more self-confident than female heterosexuals and gay men to be less defensive than male heterosexuals. In general, subsequent research comparing lesbians and heterosexual women has not found consistent differences in mental health, with the exception of lesbians' higher self-esteem (Hyde, 1985).Given the extremely homophobic societal views, it is amazing that lesbians have coped so well.

Despite the prevalence and positive adjustment of lesbians, mental health professionals have mirrored society's attitudes in their conceptualization of lesbianism and treatment of lesbians in therapy. In past decades, behavior therapists considered homosexuality a maladaptive behavior pattern and treated homosexuals with aversive procedures designed to suppress same-sex and substitute heterosexual behavior. By 1969, there were 17 entries in the Psychological Abstracts under the heading "homosexuality"; seven of these focused on "re-orienting" clients to become heterosexuals. The overall success rates of these methods with primary homosexuals were not impressive, and the painful and inhumane procedures involved contributed to the protest by gay rights and women's activists. After considerable debate, the American Psychiatric Association voted (58% in favor) in 1973 to remove homosexuality as a mental disorder. Homosexuality is now considered a disorder if the individual is distressed by same-sex arousal and wishes to become heterosexual. Since then, a survey of 2500 members of the American Psychiatric Association (TIME, 1978, in Marmor, 1980) indicated that 69% believed that homosexuality was pathological, 73% viewed homosexuals as less happy than heterosexuals, 60% perceived homosexuals as less capable of mature and loving relationships, and 43% felt that homosexuals presented a greater risk in holding a position of responsibility. In contrast, most lesbians and gay men do not want to give up their sexual orientation, express a strong need for a supportive gay and lesbian community, and do not want to go to psychiatrists (Weinberg & Williams, 1974, in Sarason & Sarason, 1984). Thus, these separate surveys indicate that mental health professionals may consider homosexuality as more ego-dystonic; whereas members of the gay and lesbian community view their sexuality as ego-syntonic.

I think it is accurate to say that the prevailing view on lesbianism by mental health professionals today is one of cautious acceptance. For example, there is an emphasis in psychology texts on the fact that homosexuals do not differ from heterosexuals in physical appearance and that there is no evidence that homosexuality is caused by genetic, hormonal, or abnormal child rearing factors. As an analogy, keep in mind that women and men differ in physical appearance, have had different certain genetic factors, hormonal levels, and child rearing experiences, score differently on some personality measures, and have different prevalence rates of mental health disorders. Yet textbooks do not label women or men pathological per se. In fact, gender has a greater influence on individuals' behavior than sexual orientation (Peplau, 1981). Similarly, therapists today communicate to their lesbian clients that lesbianism is not a disorder and that lesbians do not differ from heterosexual women. I just took my licensing exam, in which one of the questions had to do with differences

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between lesbian and heterosexual women. The choices were either that lesbians were more deviant or pathological than heterosexuals, or that there were no differences.

What I will highlight in this talk (although I would like you all to pass your licensing exams) is that lesbians are <u>not</u> just like heterosexual women. To equate lesbians and heterosexual women as similar denies several important processes that exist for lesbians and that do not exist for heterosexual women. Thus, I am affirming the non-traditional roles of lesbians. It is important to keep in mind as I review these points, however, that no research on lesbians uses a truly random sample (because of the obvious difficulties in obtaining such a sample), that many women are bisexual, and that it is difficult to know what constitutes a heterosexual control group for lesbian women.

First, although 24% of lesbians have been married previously (Ettorre,), most lesbians are not currently married to men. Being married increases the probability for women to have increased rates of mental health disorders, including depression, agoraphobia, nervousness, insomnia, inertia, and sexual abuse (c.f. Rothblum, 1983 for a review of this literature). Possible reasons for increased distress among married women have been postulated to be either the role of housewife (e.g., Gove, 1972) or the combination of employment plus full responsibility for housework and childcare (e.g., Radloff, 1975). Lesbians, like most unmarried women, are not housewives; and lesbians in couples are more likely to share housework and childcare than are married couples (Peplau, Cochran, Rook, & Padesky, 1978). Despite tremendous societal pressure for women to be married, mental health statistics reveal that being single is psychologically "healthier" (U.S. Department of Health, Education, and Welfare, 1970, in Donelson, 1977). Thus, it is important for therapists to realize that lesbianism represents not just the absence of psychopathology but <u>increased</u> mental health for women.

Secondly, lesbianism involves a process of "coming out", or acknowledging and acting on sexual attraction to women. Even women who feel they have been lesbians since birth have to actively break the expectations of their family and society. Heterosexual women are rarely confronted by an active choice about their sexual orientation. Coleman (1982) has identified five stages in this process: (1) pre-coming out, which consists of feeling different, alienated, and alone; (2) coming out, which involves facing lesbian feelings, self-acceptance, and disclosure to others; (3) exploration, which consists of experimenting with the new sexual identity; (4) first relationships; and (5) integration, that involves incorporating both private and public identity into one's self-image. The median age of coming out for lesbians is 18, of having a lesbian sexual experience is 20, and of self-identification as a lesbian is 23 (Coleman, 1982). Thus, lesbians are past their chronological adolescence by the time they begin relationships with other women.

Third, unlike gay males who report a great number of sexual partners whom they often contact anonymously, lesbians have fewer and more long-term relationships. Most lesbians meet one another through other lesbian friends, meetings of women's groups, or participation in activities sponsored by lesbian organizations (Albro & Tully, 1979). Such organizations exist

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even in small, rural communities and are easily identifiable to women who have been out for a period of time. If therapists are unaware of the lesbian and feminist organizations in their community, they will be unable to recommend ways in which their lesbian clients can overcome their isolation and become part of the lesbian community. Women's bars, probably the most visable lesbian places to the non-lesbian public, are not comfortable ways for "new" lesbians, who are likely to be socially anxious, to meet other women.

The nature of lesbian relationships needs to be understood in the context of the lesbian subculture, or "women's community". Single lesbians may feel pressured to become part of a relationship as the only way of legitimizing their lesbianism. Furthermore, lesbians are influenced by current heterosexual norms which dictate that something is wrong if one is not in a relationship (Pearlman, 1981). Women are not socialized to initiate sexual relationships. Issues of initiation, refusal, and rejection are compounded by the small size of most lesbian communities in which most women know each other, work together on community activities, and discuss each others' relationships.

Lesbian couples involve two women, and consequently there is a large emphasis on emotional closeness, love, and security (Hyde & Rosenberg, 1980). The strength of a lesbian relationship is often cited to be the level of intimacy, uniqueness, and equality that can be achieved by two women compared with a heterosexual couple (McCandlish, 1982). Consequently, lesbian couples may become overly enmeshed as they participate in similar activities and share friends. Couples who are socially isolated or who have a need for secrecy to protect employment or children may become overly interdependent (McCandlish, 1982). Jealousy is a particular concern for lesbian couples because either partner may be regarded as available by male co-workers or acquaintances (Morris, 1982). The recent bestseller American Couples (Blumstein & Schwartz, 1985) has demonstrated through interviews with heterosexual, gay, and lesbian couples that lesbian couples had the lowest frequency of sexual activity, which the authors interpret in light of women's socialization to value affection and romance rather than sexual initiation. Nevertheless, society at large (including therapists) tend to define a relationship according to the presence of sexual activity. If two people are not having sex, then they're not a couple (in contrast, the legal status of marriage defines married heterosexual couples as a unit regardless of sexual activity).

Compared with heterosexual women, lesbians are less likely to be in sexually monogamous relationships and more likely to have personal autonomy (Peplau, et al., 1978). In a study conducted by the Kinsey Institute in 1970 (Bell & Weinberg, 1978), 28% of lesbians were involved in monogamous relationships, 17% were in primary relationships that were non-monogamous, 15% had sexually active lives but no one primary partner, and 11% were engaged in little sexual activity. Very few lesbians have had more than ten sexual partners in their lives, and more than half have never had a one-night stand (Bell & Weinberg, 1978). Research has indicated that lesbians are more likely to have had orgasms and to have orgasms more frequently then are heterosexual women (Kinsey, 1953, in Peplau, 1981). On the other hand, this should not lead us to believe that lesbians experience no sexual problems. Needless to add, even casual lesbian relationships include little

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risk of sexually-transmitted disease and no risk of contraceptive-related disease. To date, no exclusively lesbian woman has contracted AIDS. Finally, therapists who advocate bisexuality should be aware that bisexuals are frequently met with hostility and distrust by the lesbian community (and are certainly not unconditionally accepted by heterosexual society).

The recent media attention over the book Lesbian Nuns:Breaking Silence (Curd & Manahan, 1985) in which 50 former and current nuns discuss their lesbianism illustrates some of the difficulties in integrating lesbianism and most major religions. It is striking how many organizations in gay pride marches in this country represent gay branches of Catholic, Protestant, and Jewish religious groups. Religious lesbians are particularly likely to experience guilt about their sexuality (although the Bible forbids only male homosexuality) and to be advised to adopt a heterosexual lifestyle (Nelson, 1982).

Few topics raise as much controversy as lesbian mothers rearing children. Although nearly all lesbians today have heterosexual parents and although research on lesbian parents has indicated that their children are heterosexual (Green, 1978), there is great concern that lesbian mothers will rear children who are either lesbian or gay (a homophobic concern in itself) or who are emotionally disturbed. Several issues confront lesbian parents that are not as frequently concerns for heterosexual parents: custody battles over competency to rear children, homophobic remarks made by others to the children, lesbian partners relating to the children, rearing male children, and coming out to children (Hall, 1981). Most of all, lesbian mothers do not fit the family mold presented by our society. We rarely permit lesbian mothers to legally gain the right to live with their children; lesbian mothers lose 80% of all custody battles in lower courts (Morgan, 1984).

It is especially difficult for lesbians who are under legal age to find acceptance and support. A librarian has described the four available books for teenagers that have gay and lesbian plots as "heterotextual"; she states: "these four stories contain eight central characters with five sets of divorced parents, two of whom are alcoholics, and have plots with three natural deaths and three car crashes, resulting in one mutilation, one head injury, and four fatalities, plus two pets' deaths by violence" (Gittings, , p. 113). Furthermore, lesbians who are minors and whose parents want them to become heterosexual present a difficult ethical issue for therapists.

Given the special issues of lesbians, who is qualified to treat lesbians in therapy? As one gay therapist has stated (Rochlin, 1982, p.21): "issues of client-therapist similarity and difference have been investigated and reported in the areas of social class, gender, race, religion, culture, politics, wealth, education, age, personality, and sexual mores, but very rarely with regard to sexual-affectional orientation". The work of Rogers (1962) and others has demonstrated that variables of empathy, positive regard, and genuineness influence therapeutic effectiveness. Therapists may not only be heterosexist, they are also likely to be unaware of lifestyle issues confronting lesbians. This is particularly grave given that many lesbians who come to therapy are struggling to come out and are not part of the lesbian community. Openly lesbian therapists working with

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lesbian clients are an ideal (if infrequent) source of support. However, lesbian therapists may also be avoided by homophobic colleagues, and by clients who are not lesbian or gay, contributing to the reluctance of lesbian therapists to come out about their own sexual orientation.

At his presidential address at AABT in 1974, Davison pointed out that "therapists never make ethically or politically neutral decisions...Any type of psychiatric intervention, even when treating a voluntary patient, will have an impact upon the distribution of power within the various social systems in which the patient moves" (Davison, 1976, p. 158). This is particularly true for lesbians, because we ignore the "normativeness" of heterosexuality. Adrienne Rich (1980) has termed this process the "bias of compulsory heterosexuality" (p. 332). Like Davison, she argues that heterosexuality needs to be understood as a political institution. Thus, Rich states: "woman-identification is a source of energy, a potential springhead of female power, violently curtailed and wasted under the institution of heterosexuality" (p. 658). In this talk, I have raised some of the issues which I consider vital to the lesbian experience and which need to be understood in the sociopolitical context of compulsory heterosexuality. Hopefully, an understanding of these issues will not only decrease homophobic stereotypes about lesbians, but also demonstrate how the lesbian experience can serve as an affirmative model of non-traditional lifestyles.

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